

STOP LOSS INSURANCE AGREEMENT

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut
(a stock insurance company)

Will reimburse the Plan Sponsor named below for Plan Benefits Paid, subject to the terms and conditions of this agreement. The insurance provided under this agreement applies only to the benefits payable under the terms and provisions of the Plan Document, except as otherwise noted.

This agreement is issued in consideration of the Application for Stop Loss Insurance and payment of the required premium.

Plan Sponsor Name: **GALION COMMUNITY HOSPITAL**

Place of Delivery: **Galion, OH**

Effective Date: **January 1, 2004**

Signed for the Hartford Life and Accident Insurance Company

by:



Michael A. Wozny
Assistant Vice President

Date of Issue: January 27, 2004



SCHEDULE F

Coverage Provided: **Individual Stop Loss**

Type of Plan: **Hartford 15/12**

Policy Number: **GRH-710796**

Monthly Premium Rate: **\$41.33 per Single Unit**
\$99.20 per Family Unit

Premium Due Dates: **First day of each calendar month**

Deductible Amount: **\$50,000 per Eligible Participant**

Reimbursement Percent: **100%**

Maximum Lifetime Reimbursement
per Eligible Participant for all
Covered Expenses: **\$1,000,000**

Terminal Liability: **None**

| Type of Benefits to which Insurance Applies | Reported Number of Single Units | Reported Number of Family Units |
|--|------------------------------------|------------------------------------|
| Medical Without Prescription Drug Card Plan | 107 | 156 |

Administrator:
North American Health Plans, Inc.
P. O. Box 9501
Buffalo, NY 14226

SCHEDULE

Coverage Provided: **Aggregate Stop Loss**

Type of Plan: **Hartford 15/12**

Policy Number: **GRH-720593**

Monthly Premium Rate: **\$5.16 per Employee Eligible Participant**

Premium Due Dates: **First day of each calendar month**

Stop Loss Determinant Factors: **\$436.48 per Single Unit**
\$1,134.86 per Family Unit

Reimbursement Percent: **100%**

Minimum First Year Aggregate Attachment Point **\$2,550,657**

Maximum Aggregate Reimbursement: **\$1,000,000**

Individual Claim Limit: **\$50,000 per Eligible Participant**

Terminal Liability: **None**

| Type of Benefits to which Insurance Applies | Reported Number of Single Units | Reported Number of Family Units |
|--|--|--|
| Medical Without Prescription Drug Card Plan | 107 | 156 |

Administrator:
North American Health Plans, Inc.
P. O. Box 9501
Buffalo, NY 14226

DEFINITIONS

The following terms have the following meaning when used in this agreement:

Administrator - The third party administrator retained by You and approved by Us to process claims for benefits under The Plan.

Agreement Year - A one year period that begins on the agreement Effective Date or subsequent anniversary of such date and ends 12 consecutive months later.

Cosmetic - Surgery or procedures that are performed primarily to change appearance, except that the repair of congenital deformities such as cleft lip or repair of facial trauma that is received within 12 months of the date of injury may not be considered Cosmetic.

Custodial - Care provided to an individual that is primarily to assist in the basic activities of daily living. Some of the care provided may be medical (such as administration of medication from a unit dose box), but the overall purpose of the care is not curative or diagnostic in nature.

Covered Expenses - Those expenses:

- That are eligible for payment under the terms of the Plan Document;
- Which represent the Type of Benefits shown in the Schedule; and
- Which arise from services and supplies that are Medically Necessary to diagnose or treat a sickness, injury or pregnancy.

With respect to expenses for services rendered by You or any of Your affiliates, only 80% of such expenses will be considered Covered Expenses.

Deductible Amount - An amount of Plan Benefits for Covered Expense which must be Paid by You for each Eligible Participant before any benefits are payable by Us under the Individual Stop Loss insurance. The Deductible Amount is shown in the Individual Stop Loss Schedule.

Eligible Participant - Any of the following persons who are eligible for benefits in accordance with the Plan Document:

- Employees and their dependents; and
- Persons for whom coverage under The Plan is continued under the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (COBRA).

Retired employees and their dependents are not deemed Eligible Participants unless they are persons for whom coverage under The Plan is continued under COBRA.

In no event will a dependent become an Eligible Participant prior to the date an employee or retired employee becomes an Eligible Participant, nor will a dependent be eligible beyond the date an employee or retired employee Eligible Participant ceases to be an Eligible Participant except to the extent coverage is required under COBRA.

Employee Benefit Plan or The Plan - The benefit plan established by You to provide benefits, as described in the Plan Document, to or on behalf of Eligible Participants and approved by us.

Experimental - An expense for a treatment, procedure, device or drug that meets one or more of the following criteria:

- It is within the research, investigational, or experimental stage.
- It involves the use of a drug, substance or device that has not been approved by the United States FDA or has been labeled "Caution: Limited by Federal Law to Investigational use" or has not successfully completed Stage 3 clinical trials for the intended treatment or disease.
- The safety and effectiveness have not been established in accordance with a majority of the medical community.

Family Unit - An employee Eligible Participant or retired employee Eligible Participant who is covered under The Plan with respect to both himself and dependents.

His - His or her.

Incurred - An expense is Incurred on the date on which the Eligible Participant receives the service or supply for which a charge is made.

Individual Claim Limit - The limit of Plan Benefits for Covered Expense which are Paid by You for each Eligible Participant which is eligible for application to the Aggregate Stop Loss Attachment Point. The Individual Claim Limit is shown in the Aggregate Stop Loss Schedule.

Medically Necessary - An expense that is recommended by a licensed medical practitioner, physician or dentist, and meets all of these tests:

- It is appropriate for the diagnosis and treatment of a sickness, injury or pregnancy in accordance with generally accepted medical practice and professionally recognized standards.
- It is the most appropriate treatment, supply, device or level of service to provide safe and adequate care.
- It is not Experimental, Cosmetic or Custodial in nature.

Paid - Drafts or checks that are issued, provided that they are promptly delivered to the payee and paid upon presentation.

Plan Benefits - Benefits available under the terms of the Plan Document.

Plan Document - The written description of The Plan, as required under ERISA and approved by Us, that is in effect on the Effective Date of this agreement.

Proof of Loss - Written evidence of a claim customarily required by the Administrator. The evidence must be satisfactory to Us. Proof of Loss is considered received when any audits, investigations or negotiations have been completed, provided that those audits, investigations or negotiations are necessary and appropriate and are completed in a timely manner.

Reasonable and Customary Charge - Charges for physicians services, hospital supplies, hospital bed rates, drugs, ancillary services and durable medical equipment usually made by such providers in the same geographical area, as determined by the Administrator using nationally and regionally adjusted data.

Single Unit - An employee Eligible Participant or retired employee Eligible Participant who is covered under The Plan with respect to himself only.

Substantive Change - Any of the following:

- A change in the Plan Benefits provided by The Plan;
- The addition or deletion of subsidiaries, affiliates or participant units or Plan Sponsors;
- Any addition or termination of any other agreement or policy of insurance between You and Us;
- A relocation of the place of business of the Plan Sponsor, or of a subsidiary, affiliate, or participant unit or Plan Sponsor; or
- Any other increase or decrease in the number of Eligible Participants that exceeds 10% of the number covered under The Plan as of the ninth month of the previous Agreement Year, with respect to any Agreement Year other than the first Agreement Year.

We, Our, or Us - Hartford Life and Accident Insurance Company or any of its designated subsidiaries or affiliates.

You or Your - The Plan Sponsor named in the Schedule. This includes Your employees, officers, agents or Administrator.

INDIVIDUAL STOP LOSS INSURANCE BENEFITS

We will reimburse You according to the terms of the agreement when the Deductible Amount has been satisfied. Plan Benefits, for Covered Expense, that are:

- Incurred while this agreement is in force or within 90 days prior to the Effective Date of this agreement;
 - Paid during an Agreement Year; and
 - Paid while this agreement is in force,
- will count towards the Deductible Amount or for reimbursement under the agreement.

If this agreement terminates during the first Agreement Year, Plan Benefits Paid which are both:

- for Covered Expenses Incurred while this agreement is in force or within 90 days prior to the Effective Date of this agreement; and
- Paid:
 - prior to the date this agreement terminates, and
 - in accordance with its terms,

will qualify for satisfaction of the Deductible Amount or for reimbursement.

If this agreement terminates during any subsequent Agreement Year, Plan Benefits Paid which are both:

- for Covered Expenses Incurred while this agreement is in force or within 90 days prior to the Effective Date of this agreement; and
- Paid:
 - during the period which begins on the first day of such subsequent Agreement Year and ends on the date this agreement terminates; and
 - in accordance with the terms of this agreement,

will qualify for satisfaction of the Deductible Amount or for reimbursement.

The Deductible Amount applies each Agreement Year.

We will reimburse You when We receive Proof of Loss and satisfactory proof that:

- Plan Benefits have been Paid in accordance with the provisions of the Plan Document and this agreement; and
- Such Plan Benefits Paid are in excess of the Deductible Amount.

Reimbursement will not exceed any applicable reimbursement percentages or maximum reimbursement amounts shown in the Schedule.

AGGREGATE STOP LOSS INSURANCE BENEFITS

The Aggregate Attachment Point for any Agreement Year is calculated in the following manner:

- multiply the number of Single Units and Family Units covered under the Plan on the first day of each month within the Agreement Year by the corresponding Stop Loss Determinant Factor shown in the Schedule; and
- add the products of each month for the entire Agreement Year.

With respect to the first Agreement Year, however, the Aggregate Attachment Point is subject to the Minimum First Year Aggregate Attachment Point shown in the Schedule.

With respect to the second and subsequent Agreement Years, the number of Single Units and Family Units used in determining the Aggregate Attachment Point will never be less than 90% of the number reported as covered as of the ninth month of the previous Agreement Year.

For each Agreement Year, only those Plan Benefits which are:

- Incurred while this agreement is in force or within 90 days prior to the Effective Date of this agreement;
 - Paid during an Agreement Year; and
 - Paid while this agreement is in force and in accordance with its terms,
- will count towards the Aggregate Attachment Point or for reimbursement under the agreement.

The Aggregate Attachment Point applies each Agreement Year.

We will reimburse You when We receive Proof of Loss and satisfactory proof that:

- Plan Benefits have been Paid in accordance with the provisions of the Plan Document and this agreement; and
- Such Plan Benefits Paid are in excess of the Deductible Amount.

Reimbursement will not exceed any applicable reimbursement percentages or maximum reimbursement amounts shown in the Schedule.

BENEFIT REQUIREMENTS

The following do not qualify under this agreement for satisfaction of any deductible or Attachment Point:

- Plan Benefits Paid after the date this agreement terminates.
- Plan Benefits Paid, after any deductible amount or attachment point has been satisfied, that are submitted by You to Us more than 12 months following the date the Plan Benefits were Paid.
- With respect to aggregate stop loss insurance, Plan Benefits Paid for which Covered Expenses were Incurred prior to the Agreement Effective Date which exceed \$456,433.
- Plan Benefits Paid for which Covered Expenses were Incurred more than 90 days prior to the agreement Effective Date.
- Plan Benefits that are Paid by You more than 31 days after the date You received Proof of Loss. If Plan Benefits are not Paid within this time limit, We will have the option to reallocate claims to the Agreement Year in which they should have been Paid.
- Plan Benefits Paid for expenses not considered a Covered Expense under the terms of the Plan Document.
- Plan Benefits Paid for a Type of Benefit that is not listed in the Schedule.
- Plan Benefits Paid because of a change in The Plan or Plan Document, unless We have agreed to such change in writing.
- Plan Benefits Paid subsequent to a Substantive Change unless We have agreed to such change in writing.
- With regard to coverage under the Aggregate Stop Loss insurance, Plan Benefits Paid for an Eligible Participant which are in excess of the Individual Claim Limit shown in the Schedule.
- Plan Benefits Paid for which You are entitled to reimbursement under any other insurance or agreement provided by Us.
- Plan Benefits Paid, regardless of the terms of Your Plan Document, for or in connection with any of the following expenses:
 - Court costs, or expenses for punitive or exemplary damages.
 - Administrative expenses.
 - Expenses that exceed the Reasonable and Customary Charge for the service or supply.
 - Expenses charged in connection with an accident or sickness arising out of any activity for wage or profit.
 - Expenses charged in connection with an injury or sickness caused by war or act of war.
 - Expenses charged in connection with an intentionally self-inflicted injury, except to the extent that You are prevented by federal law from denying such claims.
 - Expenses charged in connection with an injury or sickness received during the commission of, or attempt to commit, a criminal act.
 - Expenses for services or supplies received while incarcerated in a penal institution or in legal custody.
 - Expenses charged in connection with full-time active military service in the armed forces of any country or international authority.
 - Any expenses that arise from or are related to treatment, services, devices or supplies that are not Medically Necessary.

PREMIUMS

The monthly premium payable under this agreement will be equal to the sum of the Monthly Premium Rates multiplied by the total number of Employee Eligible Participants, Single Units and Family Units, eligible for The Plan as of each Premium Due Date.

The stop loss will automatically terminate on the 31st day after the Premium Due Date shown in the Schedule, if such payment has not been made. If You give Us advance written notice of an earlier termination date, the agreement will terminate on the earlier date.

When the agreement ends, You will be liable to Us for all premiums past due, and We may deduct from a claim reimbursement any premium due during such time the agreement was in force, but for which no premium was paid.

We may change the Monthly Premium Rates as described in the General Provisions section of this agreement.

Premium is due for each day the agreement is in force.

TERMINATION OF AGREEMENT

You may terminate this agreement for any reason by giving Us 30 days prior written notice.

We may terminate this agreement immediately under the following circumstances:

- The Plan ceases to be administered by an Administrator, unless We agree in advance to such change.
- You discontinue, modify or replace The Plan or the Plan Document, unless We agree in advance to such discontinuance, modification or replacement.
- You fail to perform any of Your duties under this agreement, and refuse to cure any such failure within 10 days of the date of Our request for You to do so, unless We agree in advance to extend the period for such cure.
- You fail to pay claims or make funds available to pay claims as required by The Plan.
- You knowingly file false claims.

Any agreement by Us to delay or forgo immediate termination must be authorized in writing by one of Our officers. No agent has authority to provide such agreement.

We may terminate this agreement for the following reasons by giving You 31 days prior written notice:

- Fewer than 50 persons are covered under the agreement.
- You fail to furnish any information which We may reasonably require.
- You fail to perform any of Your other obligations pertaining to this agreement.
- Participation in The Plan drops below 20% of your employees who are eligible to enroll in The Plan.
- For any other reason, on the first day of any Agreement Year after the agreement has been in force for 12 months.

GENERAL PROVISIONS

Entire Agreement

This agreement, together with any agreement riders and the Application for Stop Loss Insurance, copies of which are attached to this agreement, constitutes the entire contract between You and Us. Our entire obligation is set forth in this agreement. We assume no responsibility or obligation for administration of The Plan or Your acts. We reserve the right to determine amounts payable under this agreement without regard to such acts.

Monthly Reports

You will provide Us with monthly reports of Plan Benefits Paid and the number of Single Units and Family Units covered under The Plan. These reports must be sent to Us in a format satisfactory to Us and within 31 days of the last day of each calendar month during the Agreement Year.

Waiver

No act, delay, omission or course of dealing between Us and You shall constitute a waiver of any of Our rights or remedies under this agreement. No waiver, change, modification or discharge, in whole or in part, of any provision of this agreement shall be effective unless made in writing and signed by a duly authorized officer of The Hartford. Any waiver by Us of any of Our rights or remedies under this agreement shall not constitute a continuing waiver, nor a waiver of any other right or remedy.

Misrepresentation

If You have made any fraudulent misrepresentation, misstatement or omission in the information or documents You have provided to Us and upon which We relied, We reserve the right, at our discretion, to do either of the following:

- Rescind this agreement, back to either the original agreement Effective Date or to the first day of a subsequent Agreement Year; or
- Reform this agreement, its rates, deductibles, factors and conditions as We deem necessary in order to eliminate the impact of any such misrepresentation, misstatement or omission.

Inspection of Records

We have the right to inspect any of Your records or other data pertaining to The Plan, or to any information/documents You have provided Us for purposes of determining compliance with provisions of this agreement.

Amendments

We may change the rates and/or factors shown in the Schedule in the following instances by giving You 31 days written notice. Such change will become effective as of the earliest of the dates indicated below:

- The effective date of any Substantive Change;
- The date The Plan ceases to be administered by an Administrator;

- The effective date of any law or regulation, or amendment thereto, as enacted by any state or jurisdiction, which affects Our liability under this agreement, and in Our judgment, requires such a change; or
- If such change is for any reason not stated above, 31 or more days after We give You written notice. However, any change allowed by this item shall not become effective earlier than 12 months after the Agreement Effective Date, except to make corrections to cure any misrepresentation, misstatement or omission made by You and upon which We relied in Our calculations.

In addition to the above, We reserve the right to recalculate the rates and any applicable stop loss determinant factors established for any Agreement Year if reimbursement for the last two (2) months of the previous Agreement Year varies more than 10% from the average monthly reimbursement for the first ten (10) months of that Agreement Year.

We may modify the agreement by giving You written notice of the change, with respect to changes to the Plan Sponsor Name, Place of Delivery or Effective Date shown in the Schedule. Any written notice may be delivered to You or mailed to Your last address as shown on Our records. Such written notice shall, as of the effective date stated therein, supersede the applicable items of the Schedule and any prior such notice.

With respect to changes other than those described above, the agreement may be changed if You and We both agree in writing to the change.

All periods begin and end at 12:01 A.M., Standard Time at the place where this agreement is delivered.

Parties to Agreement

This agreement involves only You and Us. This agreement does not create any legal relationship between Us and Eligible Participants or beneficiaries under The Plan, nor does it create a legal right or entitlement to benefits in any other person or entity.

Subrogation

You, and any person or entity to whom You have delegated power or authority over the operation of Your Employee Benefit Plan, agree to prosecute any and all valid claims that You may have against Third Parties, or against an Eligible Participant for that Eligible Participant's recovery from Third Parties, arising out of any occurrence resulting in the payment of Plan Benefits by You or Your Employee Benefit Plan. You agree to account to Us for any amounts recovered, as described below. Should You fail to prosecute such claims and We thereupon become liable to make reimbursement to You under the terms and conditions of this agreement, then We will be subrogated to all of Your rights.

"Third Party(ies)" means any person or entity (excluding the Eligible Participant or Us) and their loss insurer, whose act or omission caused an Eligible Participant to suffer a disability for which the Eligible Participant incurs expenses covered under Your Employee Benefit Plan.

Any amounts that are recovered, either by Us or by You or by The Plan, after first deducting the expenses of collection:

- Will be deemed first to reimburse Plan Benefits Paid under Your Employee Benefits Plan for which You received, or became entitled to receive, reimbursement under this agreement; and
- Will be deemed to have been recovered as of the date these Plan Benefit payments were made under Your Employee Benefit Plan.

You agree that You will reimburse Us for all amounts that We may have paid or become liable to pay to You under this agreement, until We have been fully reimbursed or the net recovery is exhausted, whichever comes first, before You (or The Plan) become entitled to receive any balance of the recovery.

Large Claims Management

You agree to provide Us with advance written notification of any potential large claims by submitting a Stop Loss Medical Management High Dollar Notification form. The form should be submitted to us as soon as the trigger diagnosis or procedure listed on the form is known.

We reserve the right to utilize third party case management services to review, suggest and, with Your (or Your Administrator's) consent, to coordinate alternative treatment plans that are Medically Necessary, appropriate and cost-effective.

This Rider forms a part of the Stop Loss Insurance Agreement issued by HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY to:

GALION COMMUNITY HOSPITAL

Policy Number: GRH-710796

Rider Effective Date: January 1, 2004

The agreement is amended by the addition of the following provision:

ADVANCE REIMBURSEMENT

We will provide advance reimbursement to You for Plan Benefits, subject to the following terms and conditions:

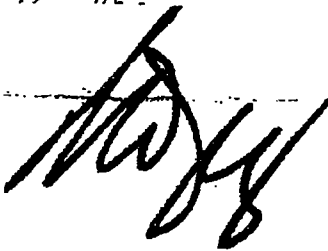
- **Once the Deductible Amount shown in the agreement has been satisfied for an Eligible Participant, during an Agreement Year, You must pay additional Plan Benefits within that Agreement Year for such Eligible Participant in excess of 20% of the Deductible Amount.**
- **The amount of Plan Benefits for such Eligible Participant that are eligible for advance reimbursement are those which both:**
 - **exceed the sum of the Deductible Amount plus the additional Plan Benefits described in the previous sub-item; and**
 - **would otherwise be eligible for reimbursement under the terms of the agreement.**
- **You agree to submit a request for advance reimbursement using a form provided by Us. Claims for Plan Benefits payable which are being submitted to Us for advance reimbursement must have been fully processed by You according to the terms of the Plan Document, and must be ready for payment.**
- **The amount of advance reimbursement You may request is subject to a minimum of \$1,000.00 per request per Eligible Participant.**
- **To be eligible for advance reimbursement with respect to an Agreement Year, Your request must be received by Us no later than the 10th calendar day following the end of that Agreement Year, provided that the agreement is in force on the date We receive the request.**

If the agreement terminates, Your request for advance reimbursement must be received by Us prior to 14 days before the date the agreement terminates.

- You agree to use the advance reimbursement amount to pay the Plan Benefits described in the second sub-item above within 5 working days of receipt of the funds from Us. Your payment within this time period will be considered Plan Benefits Paid during that Agreement Year, even if payment is made in the next following Agreement Year.
- You agree to refund to Us any amount of advance reimbursement for which payment of Plan Benefits is not made within the 5-day payment period stated above. Such refund shall be made to Us within 5 days after the end of the 5-day payment period.
- No other reimbursement shall be made under the agreement for Plan Benefit amounts for which We have provided advance reimbursement to You in accordance with this Rider.

In all other respects, the agreement remains the same.

Signed by the Insurance Company on January 27, 2004

D in


Assistant Vice President

Countersigned by Jenni A. Losel
(Licensed Resident Agent)

2/10/04
(Date)

Accepted by Traci L. Howard
(Plan Sponsor)

2/12/04
(Date)